

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5509  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH  
05500

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry</b>		First <b>William</b>	Middle <b>BAILEY</b>
4. DATE OF DEATH <b>May 29 1961</b>		Month <b>May</b>	Day <b>29</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>June 20, 1903</b>		9. AGE (in years last birthday) <b>57</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	13. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman Public Works</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
14. FATHER'S NAME <b>Rodney Ellsworth Bailey</b>		15. MOTHER'S MAIDEN NAME <b>Lillie Ridge</b>	
16. SOCIAL SECURITY NO. <b>1919 - 1925</b>		17. INFORMANT Address <b>Mrs. Maud Bailey - #30 Circla Ave, Potomac Hgts.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endotoxemia</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerosis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1 pm</b> to <b>29 May 1961</b> , that (I) (we) last saw the deceased alive on <b>29 May 1961</b> , and that death occurred at <b>4 pm</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody, MD</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>30 May 1961</b>
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		22d. ADDRESS <b>Jarwood Clinic La Plata, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/1961</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arehart Funeral Home, Inc.</b>		ADDRESS <b>Arehart Funeral Home, Inc., La Plata, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 2 '61</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. If the physician is not available, the attending physician or hospital may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5510

05501

## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY

CHARLES

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BENEDICT

c. LENGTH OF STAY IN 1b

21 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

—

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

MAY 10, 1961

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

AUG. 26, 1886

9. AGE (in years  
last birthday)

74 yrs.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

STATE INSPECTOR CALVERT CO., MD.

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

DUILLA G. BOWEN

14. MOTHER'S MAIDEN NAME

MARY ELLEN DENTON

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

No

AGNES CHING BOWEN-BENEDICT, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Urema

INTERVAL BETWEEN  
ONSET AND DEATH

4 days

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause first.

(b)

DUE TO

Acute Myelitis

7 weeks

(c)

Hypertension C.V. disease

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20e. MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

e.m.

p.m.

While

Not While

at work

at work

at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last

saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.

22e. SIGNATURE

Page Sett

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

5/14/61

22c. PHYSICIAN'S  
NAME (Type)

Page C. Sett

22d. ADDRESS

PRINCE FREDERICK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL MAY 12, 1961 SOLOMONS CATHOLIC

23b. DATE THEREOF

23c. NAME OF CEMETERY OR

23d. LOCATION (City, town or county)

(State)

SOLOMONS - CALVERT Co. MD.

24 FUNERAL DIRECTOR'S SIGNATURE

A. G. Starkness & Son - Mutual, Inc.

ADDRESS

—

25a. REC'D BY REGISTRAR

DATE MAY 12 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

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FOR STATE  
HEALTH DEPT.  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5511 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05502

1. PLACE OF DEATH a. COUNTY	Charles		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	a. STATE	Maryland		b. COUNTY
6. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Burgah		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Burgah (Rural)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	5	18	1961		
M	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-2-61					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	—	Maryland, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ulysses Bowman	Irene Proctor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	None	Irene Proctor - Burgah, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	5-2-61
583X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b)
	DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)	
Hepatitis	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
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ACTUAL SIGNATURE E. J. EDELEN	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
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EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 5-19-61
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Address (Street, city, town, or county)
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/19/61.	22c. NAME OF CEMETERY OR CREMATORIAL M. Z. Zion Baptist	22d. LOCATION (City, town, or country) Hilltop, Maryland
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23. FUNERAL DIRECTOR Arthur Funeral Home, Inc., Labadie	ADDRESS 4000295 XV3	24a. REC'D BY REGISTRAR MAY 26 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas
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TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute this certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

65503

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Kentucky</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>		c. LENGTH OF STAY IN lb <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maysville</b>	
d. STREET ADDRESS <b>55x-3</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <b>NEWTON</b> (Type or print)		First <b>MC MILLIAN</b>	Middle <b>BROTHERS</b>
4. DATE OF DEATH <b>MAY 12</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 MARCH 1894</b>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book-keeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>TOBACCO</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William</b>	14. MOTHER'S MAIDEN NAME <b>Mattie VAUGHAN</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Maurice Brothers</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion.</b> DUE TO <b>420</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary insufficiency.</b> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>1 minute.</b>	
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) <b>—</b> (State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <b>E. J. Edelen</b>			
ACTUAL SIGNATURE <b>E. J. Edelen</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. J. Edelen</b>		DATE SIGNED <b>5-12-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-15-61</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Carlisle Cem.</b>	22d. LOCATION (City, town, or county) <b>Carlisle, Kentucky</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>
ADDRESS <b>—</b>		DATE MAY 15 '61	

WEDNESDAY, SEPTEMBER 23, 1942

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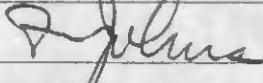
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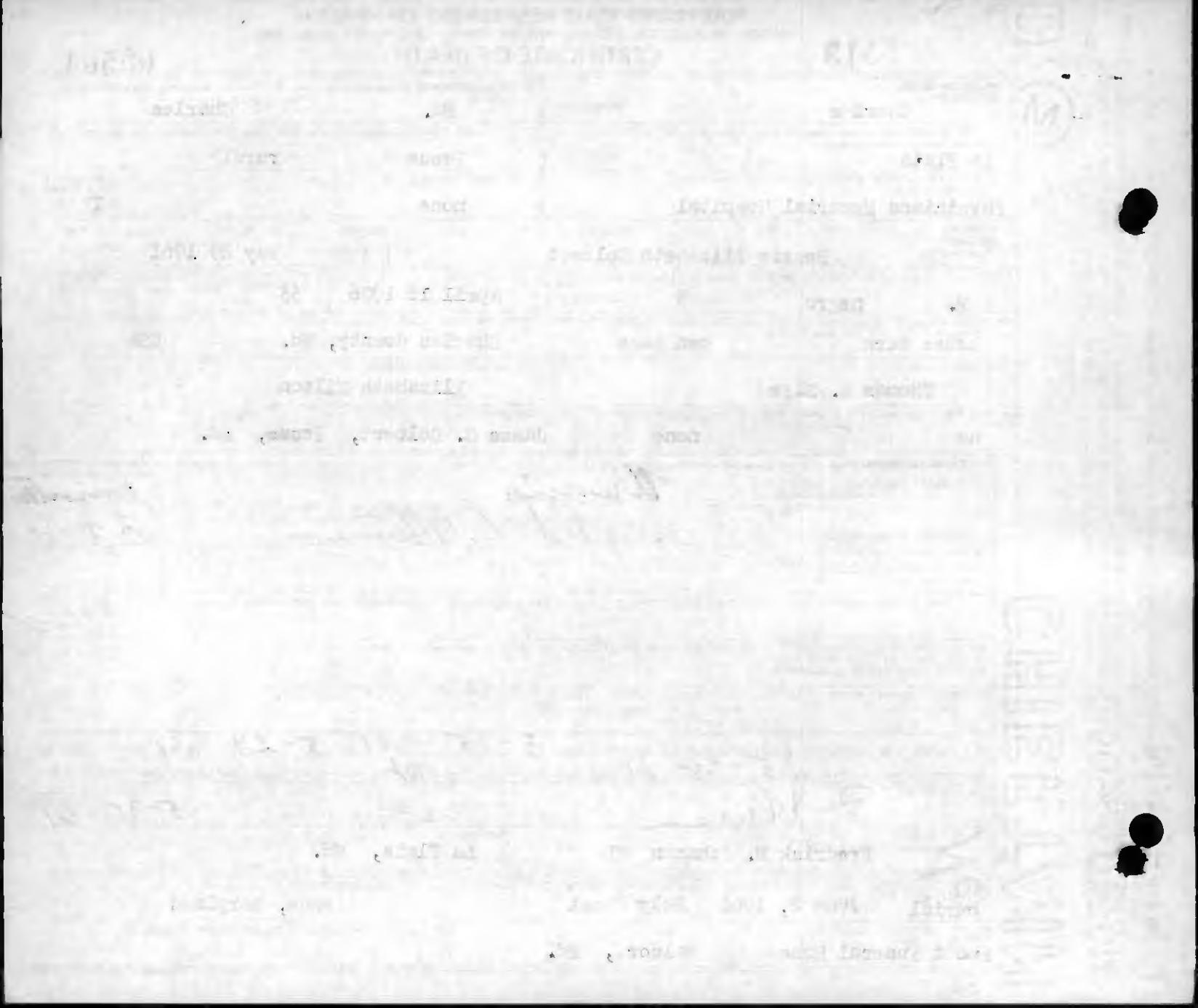
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

5513

65504

1. PLACE OF DEATH a. COUNTY <b>Charles</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Issue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>			d. STREET ADDRESS <b>none</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Bessie</b>	Middle <b>Elizabeth</b>	Last <b>Colbert</b>	4. DATE OF DEATH <b>May 29 1961</b>	Month Day Year 19 19
5. SEX <b>F.</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16 1906</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>	
13. FATHER'S NAME <b>Thomas A. Slye</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Milton</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>James C. Colbert, Issue, Md.</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  444X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO  444X DUE TO (c)			Tremia essential hypertension 1 month 2 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-15 1961</b> to <b>5-29 1961</b> , that (I) (we) last saw the deceased alive on <b>5-28 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE 			22b. DATE SIGNED <b>5-30-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Frederick M. Johnson MD</b>			22d. ADDRESS <b>La Plata, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>June 2, 1961</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Ghost</b>		23d. LOCATION (City, town, or county) <b>Issue, Maryland</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>			ADDRESS <b>Waldorf, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Clotia S. Hunt</b>



FOR STATE  
HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a longer time is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15505

5514  
1. PLACE OF DEATH  
2. COUNTY

Charles

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LA PLATA

ITEMS 3 &amp; 4 FILLED IN

c. LENGTH OF STAY IN 16

LIFE

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

b. COUNTY

MD.

CHARLES

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LA PLATA

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

Lut Her

First

Middle

Last

4. DATE  
OF  
DEATH

5

22

1961

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED  NEVER MARRIED W.DOWED  DIVORCED 

8. DATE OF BIRTH

Sept. 2, 1897

9. AGE (In years  
last birthday)63  
yrs.

10. IF UNDER 1 YEAR

Months  
Days

11. IF UNDER 24 HRS

Hours  
Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

ODD JOBS

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN COOMBS

14. MOTHER'S MAIDEN NAME

MARTHA STONE

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give rank and dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

120-1 DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause first. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a. 19. WAS AUTOPSY  
PERFORMED?YES  NO 

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While  
at work  Not While  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 

M.D.

DEPUTY MEDICAL EXAMINER 

DATE SIGNED

Address (Street, city, town, or county)

(State)

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

The Hunt Funeral Home, Waldorf, MD

DAMAY 31 '61

C. Hunt &amp; Son

VS. A15ME  
SM 7/59



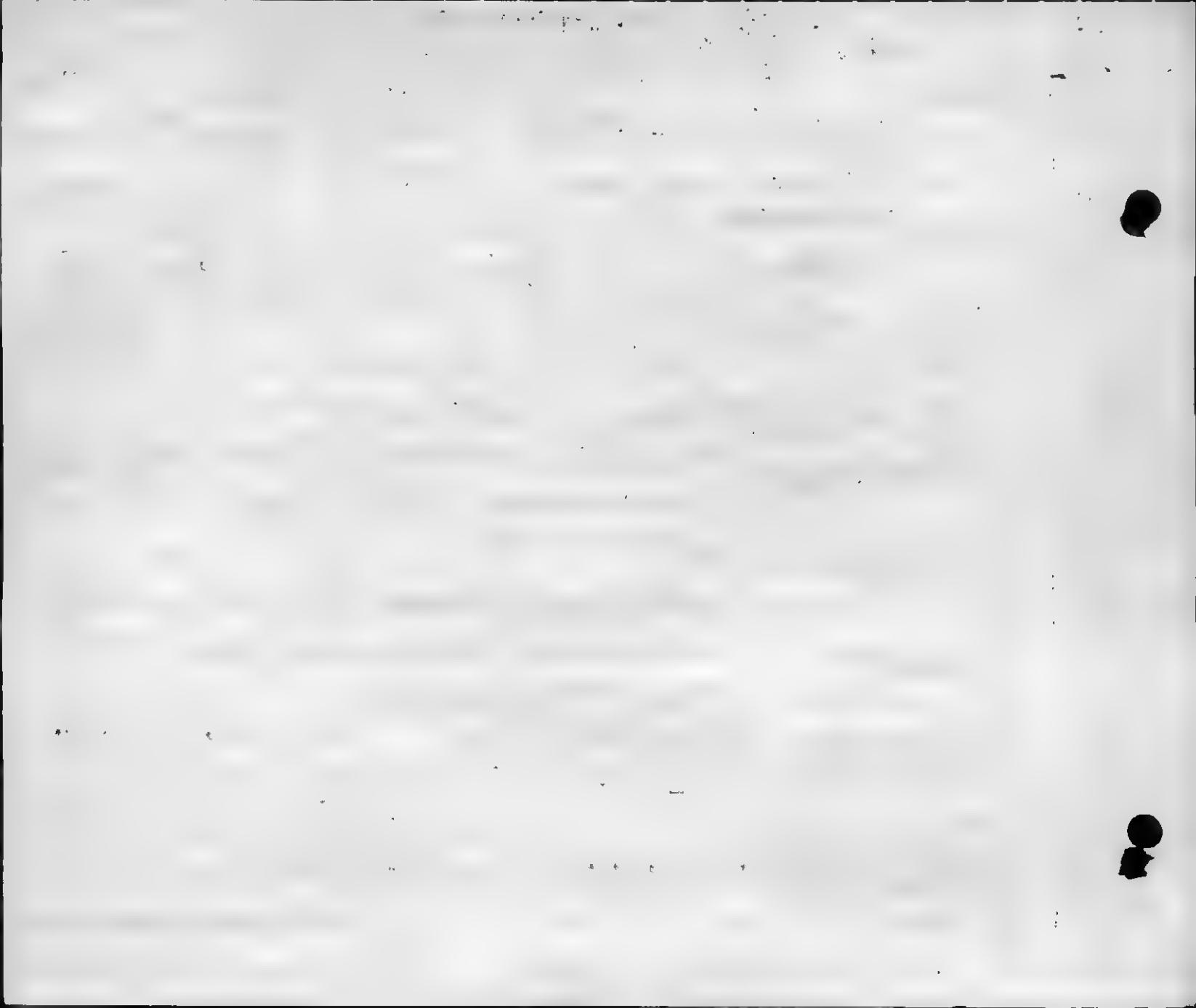
1  
FOR STATE  
HEALTH DEPT.

TO DE  
Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** (15506)

1. PLACE OF DEATH a. COUNTY <b>Charles</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>	c. COUNTY <b>Charles</b>	
c. LENGTH OF STAY IN TB <b>Physician Memorial</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physician Memorial</b>	d. STREET ADDRESS <b>Physician Memorial</b>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b>	4. DATE OF DEATH Month Day Year <b>May 11, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>White</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 17, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>Hawkins</b>	14. MOTHER'S MAIDEN NAME <b>Cooksey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>214-36-3538</b>	17. INFORMANT <b>Francis Walter, Hughesville, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>102.0</b>		DUE TO <b>Multiple fractured ribs</b>
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) } (c)		DUE TO <b>Pulmonary Atelectasis and Left Hemothorax</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of window</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3:00 AM 5/12 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	20f. (City or town) (County) (State) <b>Hughesville, Charles, Md.</b>	
ACTUAL SIGNATURE <i>Russell S. Fisher, M.D.</i>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF <b>5-16-61</b>	Address (Street, city, town, or county) <b>MT REST</b>	
23. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Waldorf, MD</b>	22d. LOCATION (City, town, or country) (State) <b>LA PLATA, MD.</b>	
VS. ATSMES SM 9/60	24a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5516

## CERTIFICATE OF DEATH

Reg. Dist. No. 05562

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural.</b>		d. STREET ADDRESS <b>Spring Hill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Middle: Fairfor First: William</b>		4. DATE OF DEATH <b>COOKSEY</b> <b>Lost</b> <b>Month: May</b> <b>Day: 15</b> <b>Year: 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 May 1870</b>	
9. AGE (In years last birthday) <b>91 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Cooksey</b>				14. MOTHER'S MAIDEN NAME <b>Sussie Elizabeth Cash</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Susie Iola Barbour - La Plata, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Report to Collyns</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <b>Hypertension</b> DUE TO (c) <b>Generalized arterosclerosis</b>				<b>2 mo.</b> <b>10 days.</b> <b>10 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign tumor prostate</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <b>19</b> <input type="checkbox"/> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>La Plata</b> (County) <b>Charles</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>15 May 1951</b> to <b>15 May 1961</b> , that I last saw the deceased alive on <b>15 May 1961</b> , and that death occurred at <b>La Plata</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>JARWOOD CLINIC</b> <b>La Plata</b> <b>16 May 61.</b>							
ACTUAL SIGNATURE <b>Arthur O. Cooody</b>		PHYSICIAN'S NAME (Type) <b>ARTHUR O. COODY</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/61</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Trinity</b>		22d. LOCATION (City, town, or county) <b>New Port</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archont Inc La Plata Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Price</b>	

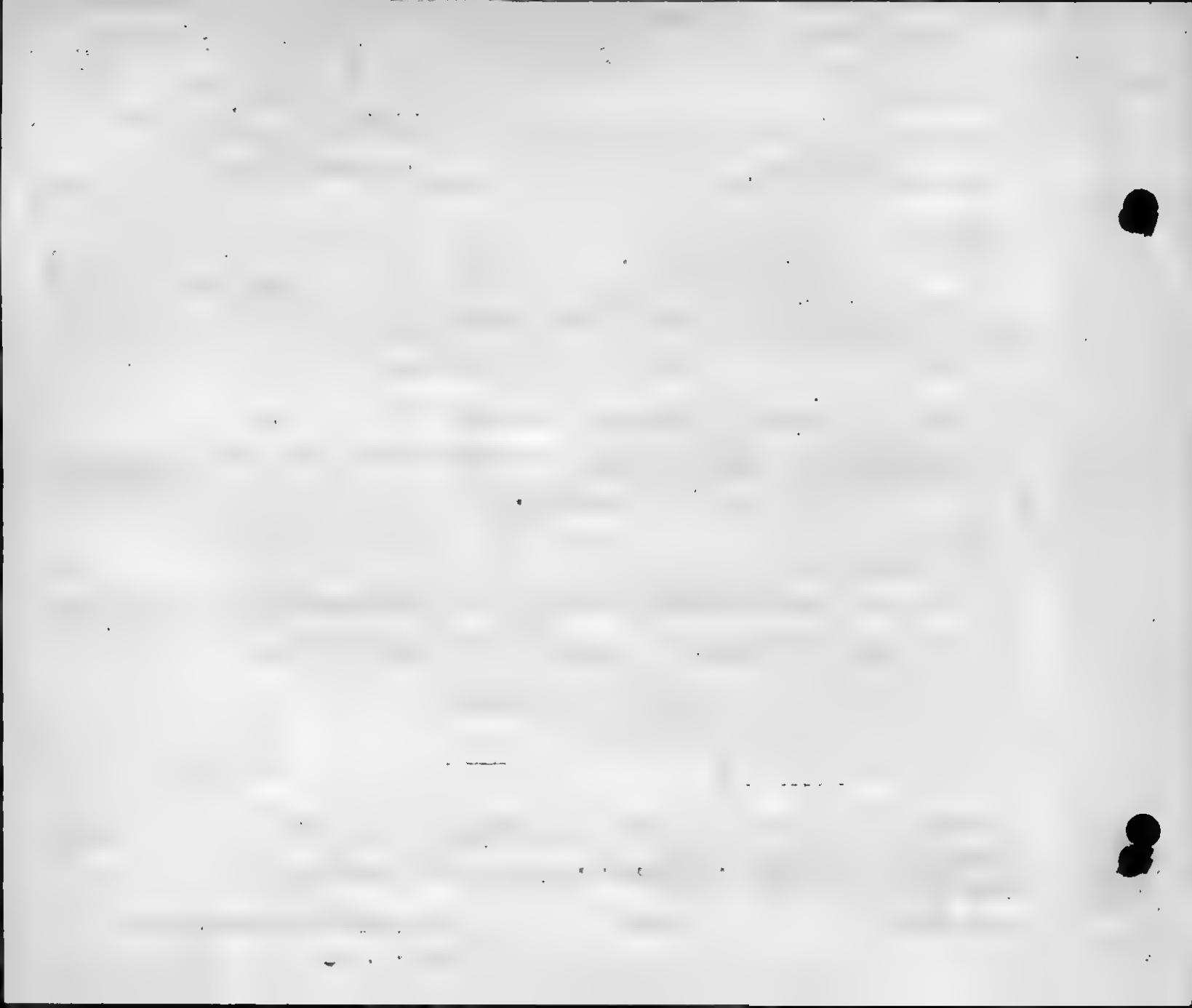


1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5513 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65508

TO DEATH  
Please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road		b. COUNTY Charles	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATIE		First O.	Middle COX
4. DATE OF DEATH May 16 1961		Month May	Day 16
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH November 29, 1903		9. AGE (in years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter Ousley		14. MOTHER'S MAIDEN NAME Viola Corklile	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or date of service No		16. SOCIAL SECURITY NO. 577-25-1400	17. INFORMANT James Cox, - Box 210 Bryans Road, Maryland Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontine Hemorrhage.			
DUE TO (b)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c)			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		DATE SIGNED 5/16/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/1961	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Hope Church Cemetery
22d. LOCATION (City, town, or county) Nanjemoy, Maryland		(State)	
23. FUNERAL DIRECTOR Arehart Funeral Home Arehart Funeral Home, Inc. - La Plata, Md.		24a. REC'D BY REGISTRAR DATE MAY 26 '61	24b. REGISTRAR'S SIGNATURE Charles S. Petty



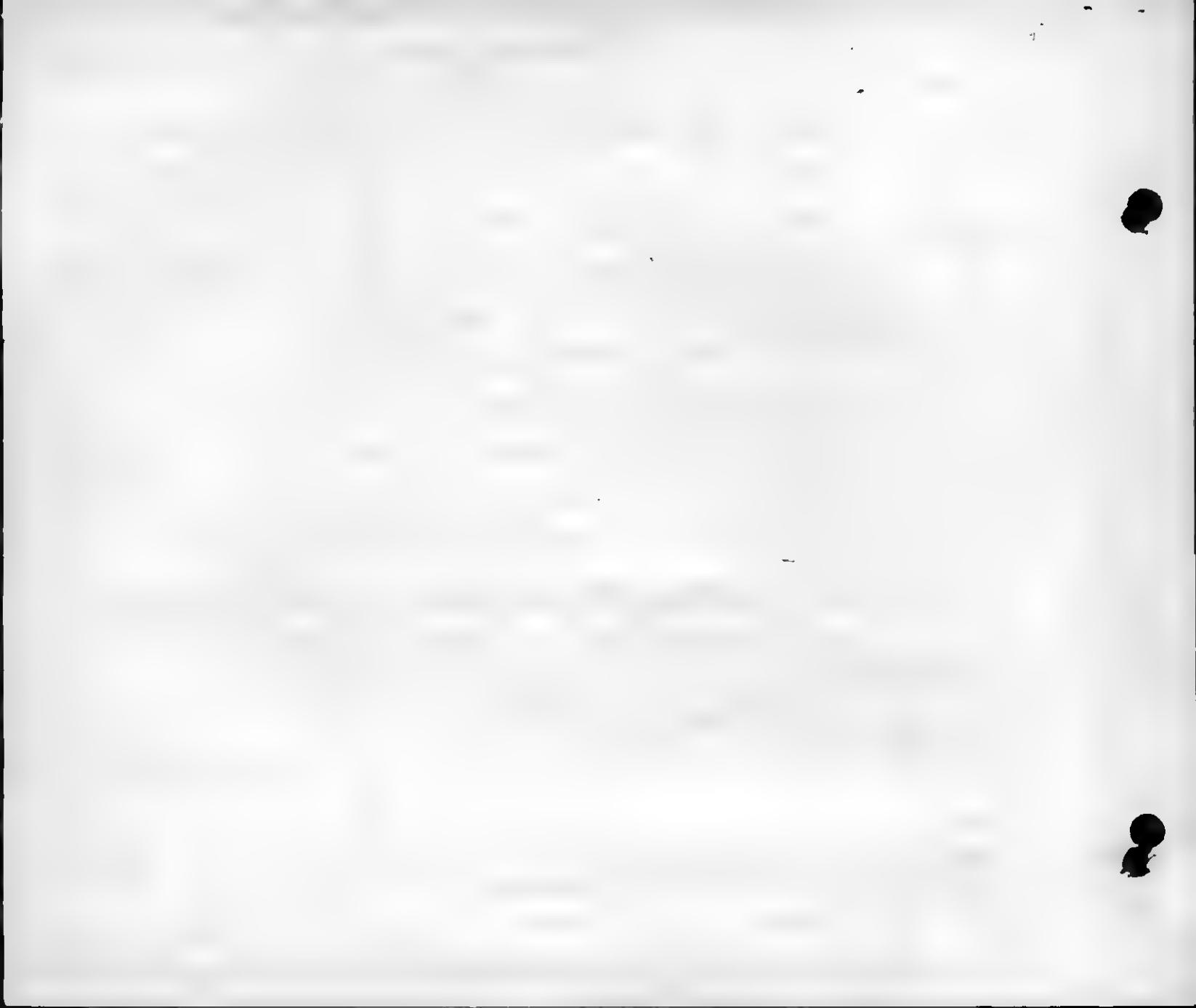
5519

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 5509

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANCES DRUSCILLA GOOD</b>		First	Middle	Last	4. DATE OF DEATH <b>MAY 5, 1961</b>	Month	Day	Year	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1908</b>	9. AGE (In years lost birthday) <b>52 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ABE GOLDSMITH</b>		14. MOTHER'S MAIDEN NAME <b>IDA GOLDSMITH</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Edwin C. Good, HUGHESVILLE, MD</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>261X</b>		DUE TO <b>Deabetic Coma</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>auto</b>		Deabetic Mellitus.				Years <b>Years</b>			
(c) <b>Hemachromatosis</b>						56 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Waldorf, Md.</b>		20f. (City or town) <b>Waldorf, Md.</b>		(County) <b>Maryland</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>May 3, 1961</b> to <b>May 5, 1961</b> that I last saw the deceased alive on <b>May 3, 1961</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>V. M. SERON MD</b>		ADDRESS (Street, city or town, state) <b>Waldorf, Md.</b>							DATE SIGNED <b>5/6/61</b>
PHYSICIAN'S NAME (Type) <b>V.M. SERON MD</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-8-61</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>OLD Fields</b>		22d. LOCATION (City, town, or county) <b>HUGHESVILLE, MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WALDORF, MD.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DATE MAY 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Julia S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05510

FOR STATE  
HEALTH DEPT.TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an  
agent is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the  
funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5519

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY

CHARLES

MARYLAND

b. CITY OR TOWN (if outside corporate limits,  
write RURAL and give nearest town)

Mason Springs

## c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Star Route #2 La Plata, Md.

3. NAME OF  
DECEASED  
(Type or print)

First FLORENCE

Middle

GRINDER

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

May 13, 1917

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House Wife

## 10b. KIND OF BUSINESS OR INDUSTRY

At Home

## 11. BIRTHPLACE (State or foreign country)

Pennsylvania

## 13. FATHER'S NAME

Roy Helsel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

## 16. SOCIAL SECURITY NO.

007-22-1411

## 17. INFORMANT

Olive Barton

## Address

Maryland

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)Drowning, secondary to overingestion of  
intermediate -acting barbituratesINTERVAL BETWEEN  
ONSET AND DEATHConditions, if any, which  
gave rise to immediate cause  
(a), spelling the underlying  
cause last.

(b)

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

## MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 9:30 AM 5/22/61 19

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Found drowned in pond

20d. INJURY OCCURRED While  
at work  Not While  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Charles Md.

21 I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from Natural causes  Accident  Suicide  Homicide  Undetermined manner 

ACTUAL

W. Bradley King, Jr., M.D.

EXAMINER'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial22b. DATE THEREOF  
5/25/1961

22c. NAME OF CEMETERY OR CREMATORY

Trinity Memorial Gardens

22d. LOCATION (City, town, or country)

Waldorf, Maryland

(State)

## 23. FUNERAL DIRECTOR

Richard Funeral Home, Inc.  
La Plata Funeral Home, Inc. La Plata, Md.

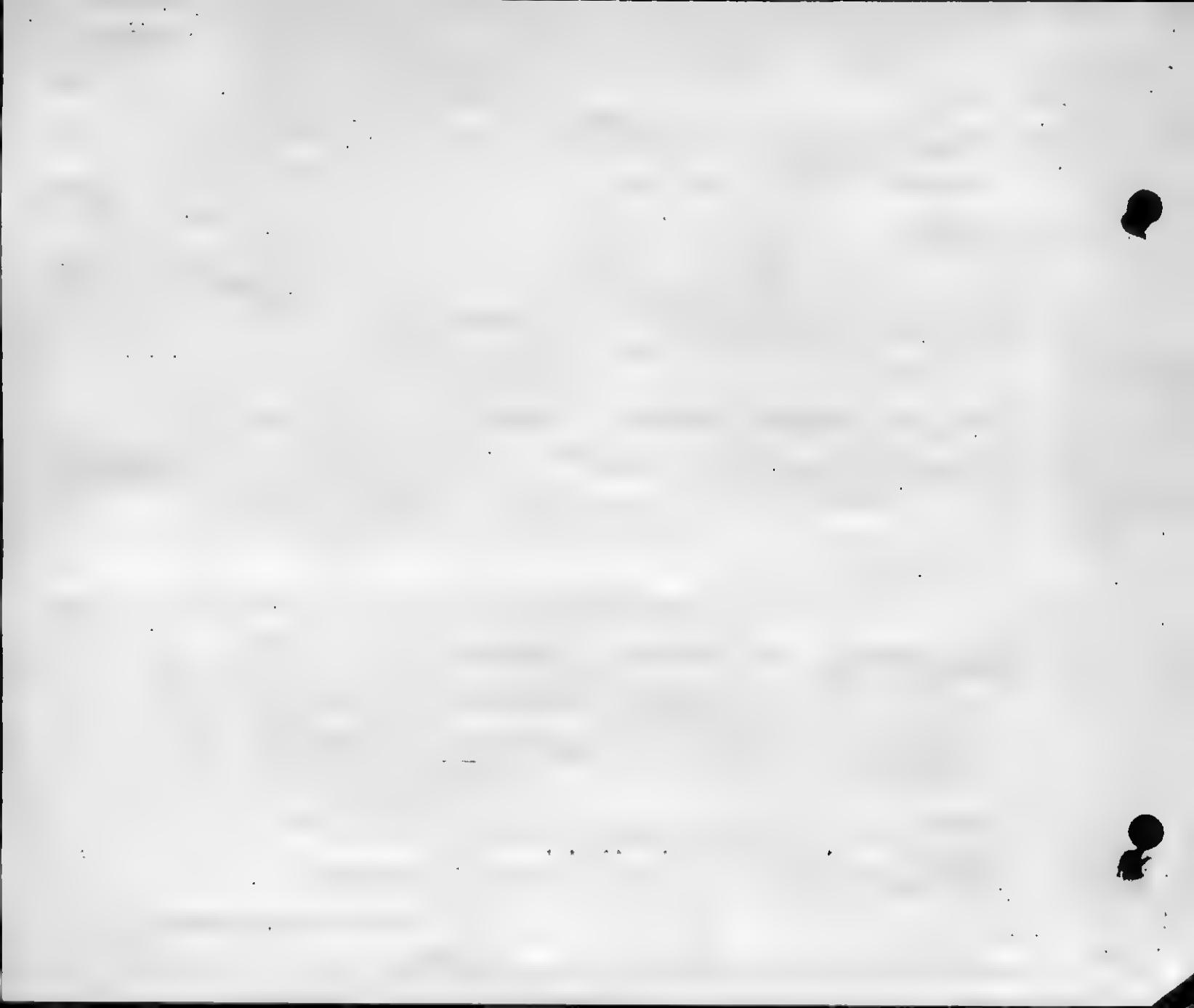
## ADDRESS

24a. REC'D BY REGISTRAR

DATE MAY 31 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN 1b 3-Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS Old Indian Head Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nettie Hardy		First	Middle	1st	4. DATE OF DEATH 5-1-61	Month	Day	Year 19
5. SEX Female	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1884 1874	9. AGE (in years last birthday) 82 86 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas O. Hodges		14. MOTHER'S MAIDEN NAME Nancy Hall Pomonkey Md.						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Bessie Keller, Indian Head Md.		7-Kelwood Place <sup>Address</sup> XXX		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH 3-Days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO <u>4214</u>						
		(b) <u>Chronic Valvular Disease—Cardiac</u>				Indefinite		
		(c) <u>Senility-Arterio Sclerosis General</u>				Indefinite		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <u>1-10-55</u> , 19 <u>19</u> , to <u>5-1-61</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>5-1-61</u> , 19 <u>19</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <u>James E. Andrews</u>						DATE SIGNED <u>5-2-61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/1961		22c. NAME OF CEMETERY OR CREMATORIUM Bimby Oak Cemetery		22d. LOCATION (City, town, or county) Pomonkey, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thies</u>		ADDRESS Rehart Funeral Home, Inc. La Plata, Maryland		24a. REC'D BY REGISTRAR DATE MAY 4 '61		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thies</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

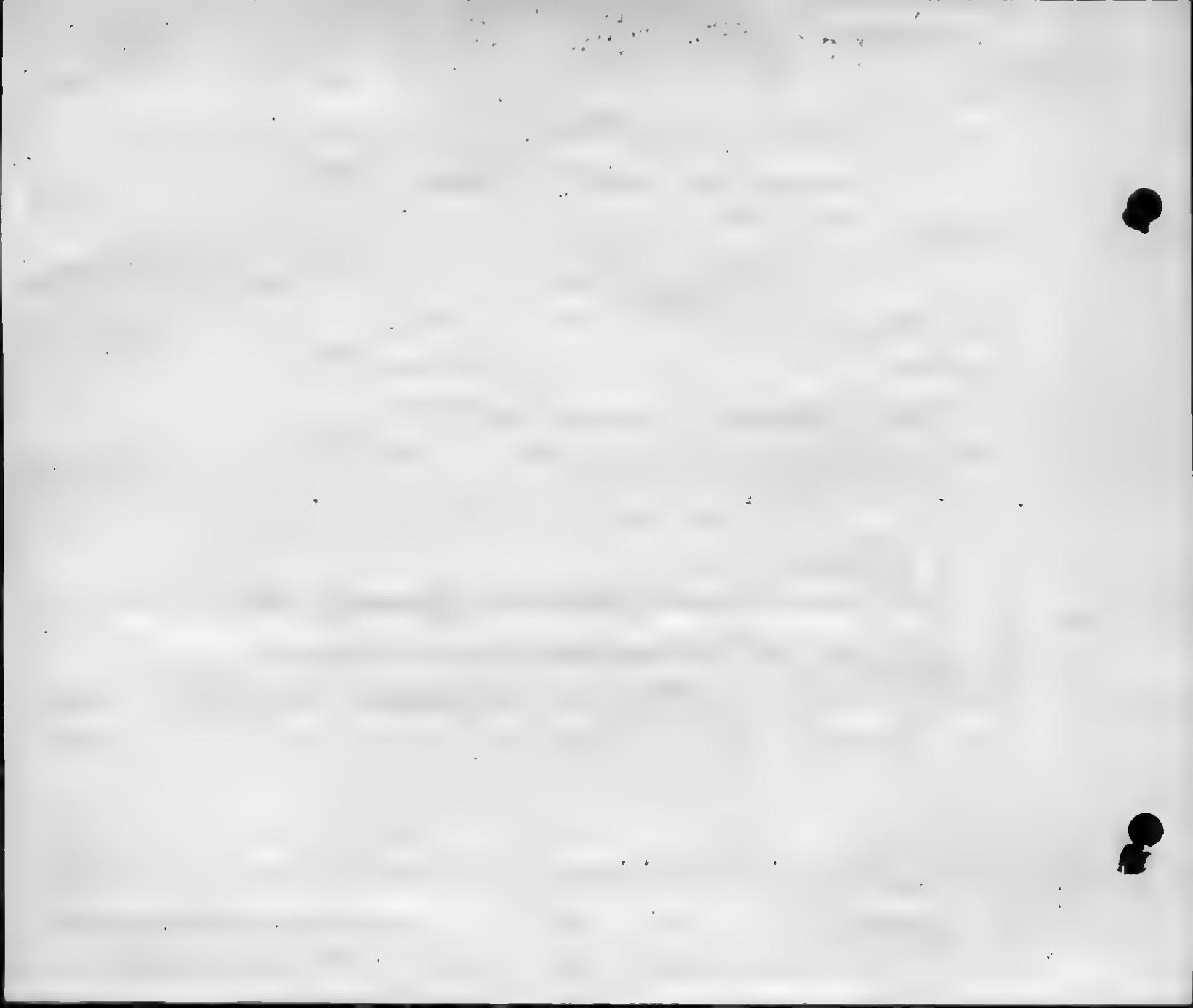


1  
FOR STATE  
HEALTH DEPT.  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65512

13 necessary,  
please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CHARLES	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy, (Rural)		f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN		First MIDDLE WAYNE		Last JENNIFER		4. DATE OF DEATH May 21, 1961	Month Day Year		
5. SEX Colored		6. COLOR OR RACE Male		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/9/59		9. AGE (In years last birthday) 2 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Marbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Jennifer		14. MOTHER'S MAIDEN NAME Ruby Keys		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ruby Jennifer - Nanjemoy, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic bronchopneumonia DUE TO otitis media		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
								(City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/22/61	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Ironside, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/1961		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Hope Church		22d. LOCATION (City, town, or county) Ironside, Maryland		(State)	
23. FUNERAL DIRECTOR Fleischman Funeral Home Inc La Plata, Maryland						24a. REC'D BY REGISTRAR DATE MAY 26 '61		24b. REGISTRAR'S SIGNATURE Charles S. Fisher	



5522

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5513

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-  
cute, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation,  
or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial for your re-  
spective office.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md</b> b. COUNTY <b>Charles</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>La Plata</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>45</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
13. FATHER'S NAME <b>Anthony Muschette</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hill</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO. <b>212-16-5755</b> 17. INFORMANT Address <b>Loretta Muschette, La Plata, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>due to</b> (c) <b>due to</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5-2-561</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>0</b> M. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Md</b> (State) <b>Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  <b>E. J. Edele</b>								
ACTUAL SIGNATURE <b>E. J. EDELEN</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5-25-61</b>		
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Josephs</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md</b> (State) <b>Md</b>				
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. DATE THEREOF <b>5-29-61</b>		22g. REC'D. BY REGISTRAR <b>DATE MAY 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. T. Evans</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold Funeral Home Waldorf Md.</b>		ADDRESS		24a. REC'D. BY REGISTRAR <b>DATE MAY 31 '61</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5523

## CERTIFICATE OF DEATH

Reg. Dist. No.

05514

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburgh (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital			d. STREET ADDRESS Avening Farm		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle STODDERT	Last REEDER	4. DATE OF DEATH Month May Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1880	9. AGE (In years last birthday) 80 yr.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Winchester, Virginia	
13. FATHER'S NAME William Reeder			14. MOTHER'S MAIDEN NAME Margaret Mc Cormack		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Foster Reeder - Box #153 Newburgh, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>May 17, 1961</u> to <u>May 20, 1961</u> , that I last saw the deceased alive on <u>May 20, 1961</u> , and that death occurred at <u>315 P St</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>J. Parran Jarboe</i>				ADDRESS (Street, city or town, state) <i>La Plata, Md</i> DATE SIGNED <i>5-20-61</i>	
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE M.D.</i>		La Plata, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/1961	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery	22d. LOCATION (City, town, or county) Wayside, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart Funeral Home Inc.</i>		ADDRESS <i>La Plata, Md.</i>	24a. REC'D BY REGISTRAR MAY 26 1961	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5524

## CERTIFICATE OF DEATH

Reg. Dist. No. 65515

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b LIFE		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Anna	Middle Corita	Last Spalding	4. DATE OF DEATH May 17 1961	Month May	Day 17	Year 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 6, 1881	9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William N. Sanders		14. MOTHER'S MAIDEN NAME Mary Louise Dement							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT Philip Spalding, La Plata, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Acute Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 7 hrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____ May, 1945, to 5-17, 1961, that I last saw the deceased alive on _____ 5-17, 1961, and that death occurred at 7 P.M., from the causes and on the date stated above. ACTUAL TIME E. J. Edelen M.D.						ADDRESS (Street, city or town, state)		DATE SIGNED 5-18-61	
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.				La Plata, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-61		22c. NAME OF CEMETERY OR CREMATORIAL ST JOSEPHS		22d. LOCATION (City, town, or county) POMFRET, MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The Huatt Funeral Home, Walkersville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 22 '61		24b. REGISTRAR'S SIGNATURE Cathleen S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



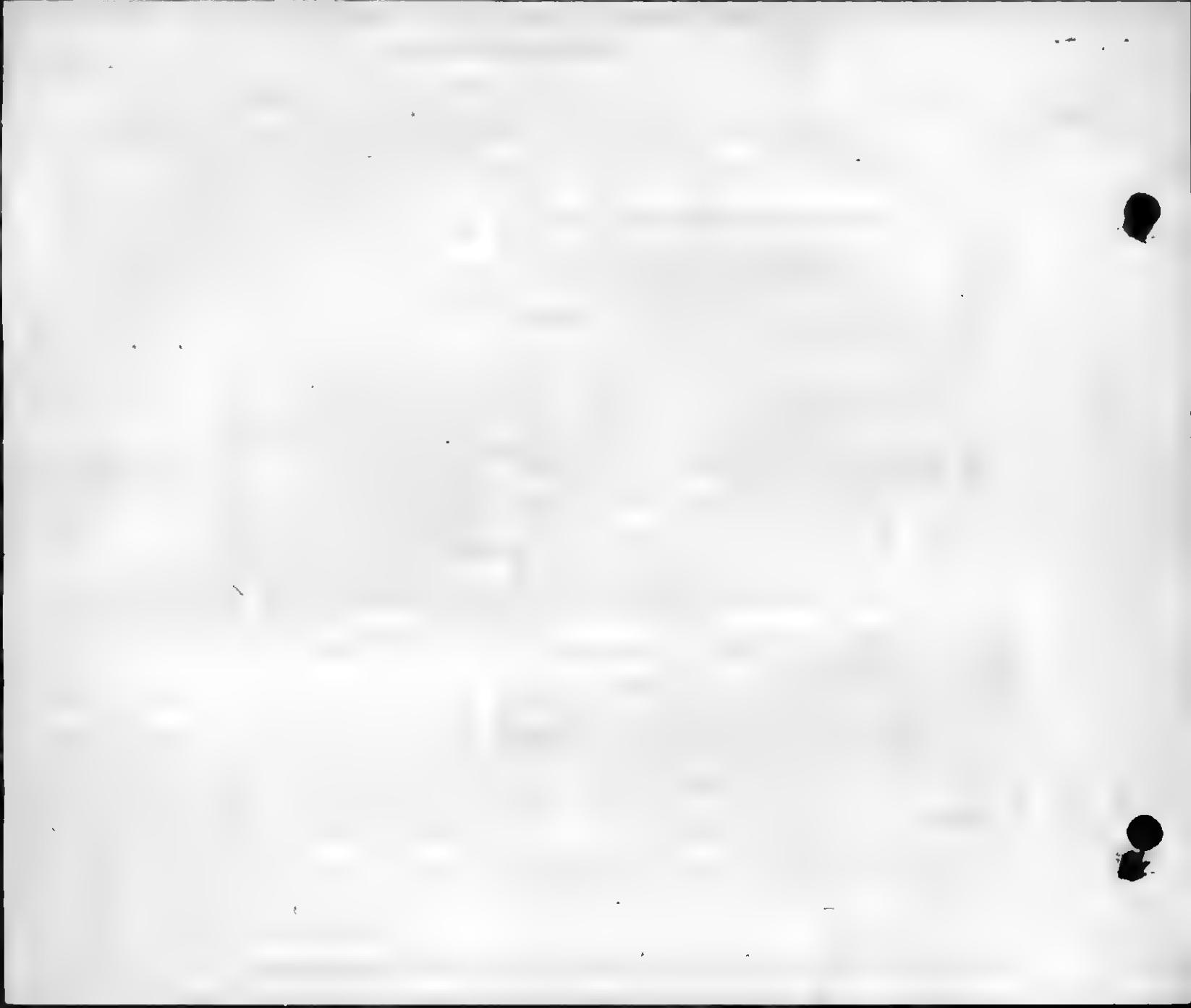
TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~urban~~ ~~ban~~ ~~lapers~~. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**  
**5525**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **05516**

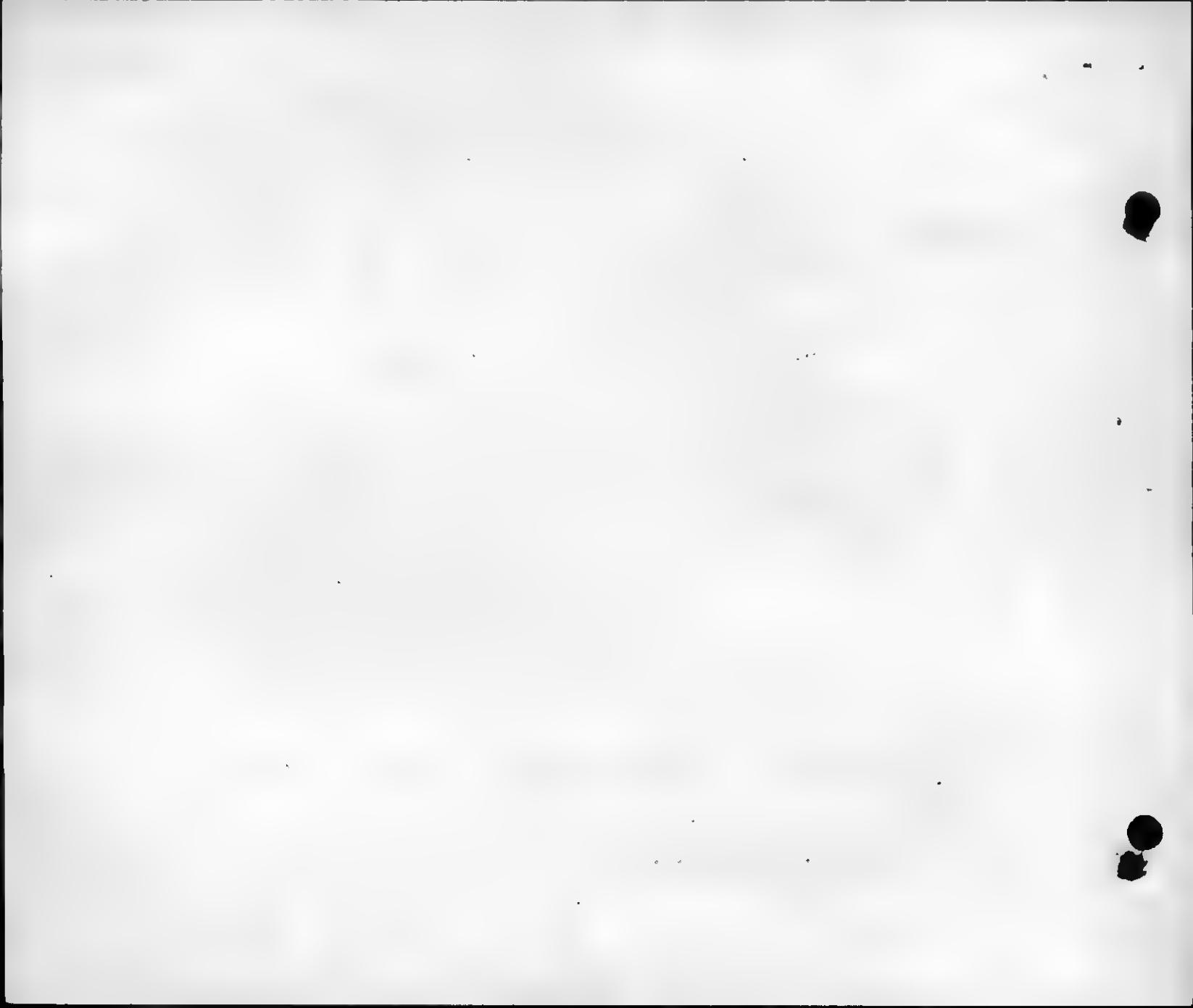
1. PLACE OF DEATH a. COUNTY <b>Charles</b>			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf - Rural</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf - Rural</b>		
c. LENGTH OF STAY IN 1b <b>Life</b>			d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>ALTON</b>	Middle <b>BONEVENTURE</b>	Last <b>WADE</b>	4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 25, 1888</b>	9. AGE (In years from birthday) <b>72</b> yrs.	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. 11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Hillary Wade</b>			14. MOTHER'S MAIDEN NAME <b>Martha Washington</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-3351</b>		17. INFORMANT Address <b>Alice Wade, Waldorf, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b> INTERVAL BETWEEN ONSET AND DEATH 5 min DUE TO 120.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Ischemia</b> 1 mo (c) <b>Chronic Coronary Disease</b> Several years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 8, 1961</b> to <b>May 18, 1961</b> , that I last saw the deceased alive on <b>May 13, 1961</b> , and that death occurred at <b>8:10 AM</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Yahesh M. Sern</b> NAME (Type)		ADDRESS (Street, city or town, state) <b>Agawam Rd 5/19/61</b> DATE SIGNED <b>5/19/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-22-61</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St Peters</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 23 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	



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1. PLACE OF DEATH a. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hughesville-Rural		LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS		Charles	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
S. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
Female		Negro		July 23, 1881	79 yrs.				
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Domestic		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Richard Sembley		Rebecca Greenfield							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		None		Ursuline Swann, Waldorf, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH			
		CEREBRAL HEMORRHAGE, RIGHT				10 days.			
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.				12 years			
		(b) ESSENTIAL HYPERTENSION				15 years			
		(c) GENERALIZED ARTERIO SCLEROSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (This hospital) attended the deceased from <u>JULY 17, 1960</u> to <u>MAY 10, 1961</u> . that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>MAY 9, 1961</u> and that death occurred at <u>10 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>5/10/61</u>			
22c. PHYSICIAN'S NAME (Type)		JOHN H. GRIFFIN M.D.		22d. ADDRESS		Hughesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county)		(State)	
Burial		5-13-61		St Marys		Bryantown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
The Huett Funeral Home, Waldorf, Md.				MAY 16 '61		Charles H. Huett			



FOR STATE  
HEALTH DEPT.

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TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Copy pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

v5518

1. PLACE OF DEATH a. COUNTY		5527 CHARLES, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Charles			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Charles Street (Route #6)		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
Xavier				WATTS	5 27 1961		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
M		Negro		Feb. 7, 1902			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Watts			14. MOTHER'S MAIDEN NAME Liza Thompson		Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank and date of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Augustus Watts - La Plata, Maryland		
No			None		INTERVAL BETWEEN DEATH AND DEATH 5-27-61		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			CRUSHED HEAD & CHEST		DUE TO		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)					DUE TO		
812X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)					DUE TO		
Hit By Two Autos					DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit By 2 Autos - Pedestrian		20c. TIME OF INJURY Month, Day, Year 9:30 a.m. 5-27-61		
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) AWAY RTE LA PLATA MD		20f. (City or town) LA PLATA CHAS MD (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
ACTUAL SIGNATURE E.J. Edelen					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) E.J. Edelen					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 5/30/1961		DATE SIGNED 5-27-61		
22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Church			22d. LOCATION (City, town, or country) La Plata, Maryland				
23. FUNERAL DIRECTOR Arehart Funeral Home, Inc. La Plata, Md.			24a. REC'D BY REGISTRAR MAY 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



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FOR STATE  
HEALTH DEPT.

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4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your  
TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
e. COUNTY

Charles

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hughesville, Md.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Home of Midwife, Catherine Dorsey

3. NAME OF  
DECESSED  
(Type or print)

First  
John  
Infant

Middle  
Francis

Last  
Woodland

4. DATE  
OF  
DEATH

5

15

1961

5. SEX

6. COLOR OR RACE

Male

Negro

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

5-15-'61

9. AGE (In years  
last birthday)  
yrs.

10. IF UNDER 1 YEAR  
Months Days

11. IF UNDER 24 HRS.  
Hours Min

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maryland

U.S.A.

13. FATHER'S NAME

Mason Jenifer

14. MOTHER'S MAIDEN NAME

Sarah Elizabeth Woodland

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Catherine Dorsey, Hughesville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

7620

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Probable Aspiration of Amniotic Fluid

INTERVAL BETWEEN  
ONSET AND DEATH

30 min

MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a.m.  
p.m.

While at work  Not While at work

factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

20g. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  20h. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED? YES  NO

Cried spontaneously but had lots of blood & fluid from mouth

20e. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  20f. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5-15-'61

ACTUAL  
SIGNATURE

E. J. Edelen, M.D.

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,  
REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or country) (State)

Burial

5-15-61

Family Cemetery  
ADDRESS

Mechanicsville, Md

23. FUNERAL DIRECTOR

Hontt Funeral Home Waldorf Md

RECD'D BY REGISTRAR MAY 17 '61

REGISTRAR'S SIGNATURE

12/20/00

MAILING AND MAILING THE 2000TH MAILING



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